RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for Sporanox

Date:_____

As the primary medical caretaker for _____, who has a diagnosis of _____, it is my considered opinion that he/she requires a prescription to take Sporanox in capsule formulation. The patient's prognosis is _____. The following criteria have been met:

1. The medication will be utilized to treat one of the following two conditions (please check one box):

☐	Histoplasmosis
☐	Aspergillosis

I understand Sporanox may only be prescribed under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record
2. The patient has been diagnosed with either histoplasmosis or aspergillosis.

Sincerely,

_____, M.D.

_____ _____
Print M.D.'s name Florida medical license # (MEO#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

Please note: All questions should be addressed to Mr. Daniel T. Wall, Assistant Director, Office of Strategic Business Management, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I service agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

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